Commonwealth of Virginia
Department of Social Services

Neighborhood Assistance Program
Services Contribution Data Sheet

To Be Used For Donated Medical Professional & Mediation Services
(Use Additional Sheet of Paper if Necessary)

PRINT NAME OF DONOR: _____

ADDRESS: _____

TYPE OF SERVICE PROVIDED: _____

JOB TITLE	**DATE** (List each date separately)	**HOURLY RATE** (excludes fringes)	**TOTAL HOURS WORKED**	**TOTAL VALUE** (Rate x Hours)

NOTE: Other formats providing the same information will be accepted. Sign and attach this form to the CNF or other format and return to the NAP Organization.

CERTIFICATION BY MEDICAL PROFESSIONAL: I certify that the value of the donated service(s) was determined by the standards stated in the instructions and does not exceed the statutory maximum. I also certify I will not receive any type of compensation or reimbursement from insurance filing or from my company for the donated service(s) nor will my company receive any compensation. I understand that if I falsify information, I may be subject to penalties prescribed by the Virginia Departments of Taxation and Social Services.

_____ _____ _____
Date Signature of Donor Phone Number

Revised 06/12
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